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| 様式第６号 | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | |  | | | | | |  | | |  | |
|  | | | | | 障害児通所給付費支給変更申請書兼 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | | 利用者負担額減額・免除等変更申請書 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| 時津町長　殿 | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| 次のとおり申請します。 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
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| 申　請　者 | | フリガナ | | | | | |  | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | 年 月 日 | | | | | | | | | | | |
| 氏名 | | | | | |  | | | | | | | | | | | | | | | | |  | | |
| 個人番号 | | | | | |  | |  |  | |  | |  |  | |  | |  |  |  | |  | |  | |  | | | | |  | | | | | | | | | | | |
| 居住地 | | | | | | 〒 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| フリガナ | | | | | | | |  | | | | | | | | | | | | | | | | | | | | 生年月日 | | | | | 年 月 日 | | | | | | | | | | | |
| 支給申請に係る児童氏名 | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| 続　柄 | | | | |  | | | | | | | | | | | |
| 個人番号 | | | | | | | |  | |  |  | |  | |  |  | |  | |  |  |  | |  | |  | |
| 身体障害者  手帳番号 | | |  | | | | | | | | | 療育手帳  番　号 | | | | | | |  | | | | | | | | | | | 精神障害者保健  福祉手帳番号 | | | | |  | | | | | | 疾病名 | | |  |
| 被保険者証の記号及び番号(※) | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | 保険者名及び番号(※) | | | | | | |  | | | | | | | | |
| * 「被保険者証の記号及び番号」欄及び「保険者名及び保険者番号」欄は、肢体不自由児通所医療を申   請する場合記入すること。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| サービス利用の状況 | 障害福祉  関係サービス | | | | | | 利用中のサービスの種類と内容等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 変更の理由 |  |

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| 申請する支援 | | 支援の種類 | | | | 申請に係る具体的内容 | |
| □ | 児童発達支援 | | |  | |
| □ | 医療型児童発達支援 | | |
| □ | 放課後等デイサービス | | |
| □ | 居宅訪問型児童発達支援 | | |
| □ | 保育所等訪問支援 | | |
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| 主治医（※） | 主治医の氏名 | | | | |  | 医療機関名 | | |  | | | | |
| 所　在　地 | | | | | 〒 | | | | | | | | |
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| 申請する減免の種類 | □ | Ⅰ | 負担上限月額に関する認定 | | | | | | | | | | |  |
|  |  | 下記の区分の適用を申請します。 | | | | | | | | | | |  |
|  | （あてはまるものに○をつける。いずれにも当てはまらない場合は空欄とすること。） | | | | | | | | | | |  |
| １．生活保護受給世帯 | | | | | | | | | | | | |
| ２．市町村民税非課税世帯に属する者 | | | | | | | | | | | | |
| ３．市町村民税課税世帯(所得割28万円未満)に属する者 | | | | | | | | | | | | |
| □ | Ⅱ | | 多子軽減措置に関する認定 | | | | | | | | | |  |
|  |  | | 下記の区分の適用を申請します。 | | | | | | | | | |  |
|  | | （あてはまるものに○をつける。） | | | | | | | | | |  |
| １．第２子に該当する者 | | | | | | | | | | | | |
| ２．第３子以降に該当する者 | | | | | | | | | | | | |
| ※　在園証明等が必要となります。 | | | | | | | | | | | | |
| □ | Ⅲ | 生活保護への移行予防措置(自己負担減免措置、補足給付の特例措置）に関する認定 | | | | | | | | | | |  |
|  |  | 生活保護への移行予防措置(□自己負担減免措置　□補足給付の特例措置)を申請します。 | | | | | | | | | | | |
| ※　福祉事務所が発行する境界層対象者証明書が必要となります。 | | | | | | | | | | | |  |
| いずれも、事実関係を確認できる書類を添付して申請すること。 | | | | | | | | | | | | | | |
| 申請書提出者 | | | | | □申請者本人　　□申請者本人以外（下の欄に記入） | | | | | | | | | |
| 氏名 | | | | |  | | |  | | | 申請者との関係 | |  | |
| 住所 | | | | | 〒 | | | | | | | | | |
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